GD NEWS / APRIL 2017

IN THIS EDITION

Page 1

NSW CTP Reform

Page 6

Driver of forklift not the owner's agent

Page 8

Court refuses leave to join insurer

Page 9

Is PTSD a bodily injury?

Page 10

Labour hire employer liable

Page 11
Construction Roundup

- Service of formal documents by USB stick not acceptable
- Sequestration to enforce adjudication judgments

Page 14
Employment Roundup

- Re-instatement of injured workers – reason for dismissal is crucial

Page 14
Workers Compensation Roundup

- Parliamentary review into the Worker's Compensation Scheme
- Reasonable actions by employers – a medical issue not just a factual one

NSW CTP Reform - A New No Fault Scheme From 1 December 2017

The NSW CTP scheme has been radically reformed with the introduction of the Motor Accident Injuries Act 2017 on 30 March 2017. The legislation establishes a compensation regime that supports people injured in motor accidents including those at fault and will reduce the cost of Green Slips for vehicle owners. The commencement date for the new scheme has not been proclaimed however the Government has announced the scheme will begin on 1 December 2017 and apply to motor accidents that occur after that date.

The key elements of the new regime are:

- a privately underwritten scheme,
- statutory benefits available to everyone injured on the roads with the benefits available to those at fault receiving benefits for a more restricted period;
- the statutory benefits include weekly compensation and treatment and care costs for varying periods depending on the nature of the injuries suffered and whether a person was at fault;
- damages will be available to those who were not at fault and have more than minor injuries. No damages can be awarded to an injured person if the person's only injuries resulting from the motor accident were minor injuries. The term "minor injury" is defined and includes soft tissue injuries and minor psychological or psychiatric injuries;
- damages awards will be restricted to past and future economic loss except where the degree of permanent impairment of an injured person as a result of an injury caused by a motor accident is greater than 10% and then damages for non economic loss to compensate for pain and suffering and the loss of amenities of life will also be available up to a maximum of $521,000;

Editors:

David Newey

Amanda Bond

GILLIS DELANEY LAWYERS
LEVEL 40, ANZ TOWER
161 CASTLEREAGH STREET
SYDNEY NSW 2000
AUSTRALIA
T: + 61 2 9394 1144
F: + 61 2 9394 1100
www.gdlaw.com.au

- damages are not awarded for treatment and care including the provision of gratuitous care or commercial care;
- a new dispute system.

A soft tissue injury is defined as an injury to tissue that connects, supports or surrounds other structures or organs of the body (such as muscles, tendons, ligaments, menisci, cartilage, fascia, fibrous tissues, fat, blood vessels and synovial membranes), but not an injury to nerves or a complete or partial rupture of tendons, ligaments, menisci or cartilage.

A minor psychological or psychiatric injury is defined as a psychological or psychiatric injury that is not a recognised psychiatric illness.

The regulations may also prescribe that specified types of injuries are soft tissue injuries or minor psychological or psychiatric injuries.

The treatment and care costs which will be met will include payment for:

- medical treatment (including pharmaceuticals);
- dental treatment;
- rehabilitation;
- ambulance transportation;
- respite care;
- attendant care services;
- aids and appliances;
- prostheses;
- education and vocational training;
- home and transport modification;
- workplace and educational facility modifications;
- such other kinds of treatment, care, support or services as may be prescribed by the regulations to the Act.

It is important to note there are key triggers which will dictate the compensation benefits which will be available. Those triggers are:

- whether the injured person was at fault;
- whether the injured person suffered minor injuries only;
- whether the degree of permanent impairment caused is greater than 10%.

These triggers are likely to become the focus of disputes under the new scheme.

Statutory benefits are not payable if compensation under the Workers Compensation Act 1987 (workers compensation) is payable in respect of the injury concerned. However there isn't a significant overlap between the CTP and workers compensation accidents. In 2012 the workers compensation scheme was amended to remove cover for journey claims and following those amendments workers injured in a journey between the worker's place of abode and their workplace are not entitled to workers compensation benefits unless there is a real and substantial connection between the employment and the accident or incident out of which the personal injury arose. Persons injured in motor accidents on these journeys who are not entitled to workers compensation benefits will now be entitled to statutory benefits under the Motor Accident Injuries Act effectively addressing a gap in compensable benefits created by removing journey claims from the workers compensation regime.

The scheme provides three entitlements:

- Statutory benefits-weekly payments;
- Statutory benefits-treatment and care;
- Common Law Damages.

An injured person will not be entitled to statutory benefits for treatment and care expenses incurred more than 26 weeks after the motor accident and will not receive weekly payments after 26 weeks if:

- the motor accident was caused wholly or mostly by the fault of the person and the person was over 16 years of age at the time of the motor accident, or
- the person's only injuries resulting from the accident were minor injuries.

Statutory benefits are not payable to an injured person after the person has been charged with or convicted of a serious driving offence that was related to the motor accident. Serious offences are the major offences under the Road Transport Act 2013 or an offence under section 115 or 116 (2) (a)–(e) of that Act. The Regulations to the new Act can also prescribe offences to be serious offences.

Contributory negligence will reduce any entitlement to weekly payments for any period of loss of earnings or earning capacity that occurs more than 26 weeks after the accident. Contributory negligence must be applied where drugs or alcohol, or any failure to wear a seatbelt or for motorcyclist helmet has been a factor in the accident or injury.

A claim for statutory benefits will be required to be made within 3 months of the motor accident.

Statutory benefits will be payable by the insurer of the at fault vehicle.

A claim for damages cannot be made until 20 months after the motor accident unless the claim relates to a death or the degree of permanent impairment is greater than 10% and all claims must be made within 3 years after the accident.

Statutory payment claims cannot be settled for lump sums.

A claim for damages by an injured person cannot be settled within 2 years after the motor accident unless the degree of permanent impairment of the injured person as a result of the injury caused by the motor accident is greater than 10%.

A damages claim cannot be settled unless the claimant is represented by an Australian legal practitioner, or the proposed settlement is approved by the Dispute Resolution Service.

If damages are payable the award will be reduced by the amount of weekly payments made and there will be no entitlement to statutory benefits after resolution of a damages claim.

A claimant must comply with any request by the insurer:

- to undergo a medical or other health related examination by one or more health practitioners nominated by the insurer, or
- to undergo a rehabilitation assessment or an assessment to determine attendant care needs by a qualified person nominated by the insurer, or
- to undergo an assessment to determine functional and vocational capacity (including pre-accident or post-accident earning capacity) by a qualified person nominated by the insurer, or
- to undergo an assessment in accordance with the Motor Accident Guidelines.

If the claimant fails without reasonable excuse to comply with an examination request by the insurer:

- the claim cannot be referred for assessment and any assessment underway cannot be continued while the failure continues, and
- weekly payments of statutory benefits are suspended for any period during which the failure continues, and
- court proceedings cannot be commenced or continued in respect of the claim while the failure continues.

So what are the benefits?

Weekly Compensation

In the first 13 weeks a person who is an earner, a term defined in the Act, will be entitled to 95% of the difference between the person's pre-accident weekly earnings and the person's post-accident earning capacity.

After that for the period from 14 to 78 weeks, a totally incapacitated person who was an earner will be entitled to 80% of the person's pre-accident weekly earnings; those suffering a partial loss of earning capacity will be entitled to 85% of the difference between the person's pre-accident weekly earnings and the person's post-accident earning capacity.

The maximum amount of weekly statutory benefits is set at 2.5 times average weekly earnings ($3,853). A minimum will also be prescribed by the regulations. Payments are payable on a fortnightly basis.

A person who is injured as a result of a motor accident is an "earner" if the person is at least 15 years of age and who:

- was employed or self-employed (whether or not full-time):
  - at any time during the 8 weeks immediately preceding the motor accident, or
  - during a period or periods equal to at least 13 weeks during the year immediately preceding the motor accident, or
  - during a period or periods equal to at least 26 weeks during the 2 years preceding the motor accident,

  and, at the date of the motor accident, had not retired permanently from all employment, or
- before the motor accident, had entered into an arrangement (whether or not an enforceable contract):
  - with an employer or other person to undertake employment, or
  - to commence business as a self-employed person,

  at a particular time and place, or
- was receiving a weekly payment or other payment.

No weekly payments are payable to an injured person who was not an earner in the first 78 weeks.

After the 78 week period the concept of "earner" is not as significant as a person will be entitled to weekly payments if at least 18 years of age or under 18 years of age and is an earner

However the entitlement to weekly payments is also restricted as follows:

- to 26 weeks where the motor accident was caused wholly or mostly by the fault of the person;
- to 26 weeks where the person's only injuries resulting from the motor accident were minor injuries;
- to 104 weeks, unless the person's injury is the subject of a pending claim for damages (whether or not the insurer has accepted liability);
- to 156 weeks if the person's injury is the subject of a pending claim for damages and the degree of any permanent impairment of the injured person is not greater than 10%;
- to 260 weeks if the person's injury is the subject of a pending damages claim and the degree of permanent impairment of the injured person is greater than 10%;

- payments are not available beyond the first anniversary of the retirement age of a person;
- payments are not available whilst a person resides outside Australia unless the Dispute Resolution Service determines the loss of earnings is likely to be of a permanent nature.

The Act provides that a motor accident is caused mostly by the fault of a person if the contributory negligence of the person in relation to the motor accident is greater than 61%.

The key triggers to determine weekly entitlements will be:

- whether the person injured was an earner;
- whether the person injured was mostly at fault;
- whether the only injuries are minor injuries;
- whether a damages claim is on foot;
- whether the permanent impairment of the injured person is greater than 10%,
- whether there was contributory negligence on the part of the person.

An insurer will be entitled to require an injured person to provide medical certificates as to fitness and authorisations to their treating medical practitioners to release information. If an injured person fails to comply with this request within 7 days the weekly payments can be suspended (subject to the Motor Accident Guidelines).

Treatment and Care

No statutory benefits are payable for the cost of treatment and care to the extent that the treatment and care concerned was not reasonable and necessary in the circumstances.

Statutory benefits are not paid for gratuitous attendant care services.

Payments will be made for attendant care but only in limited circumstances.

Motor Accident Guidelines may include provision for the following in connection with statutory benefits payable for treatment and care expenses:

- limiting the amount of statutory benefits payable for any particular treatment and care;
- approving particular treatment and care as appropriate treatment and care in respect of any matter;
- limiting attendant care services for which statutory benefits are payable to services provided by providers of an approved class or with approved competencies.

Treatment and care costs are not payable while a person is residing outside Australia.

Treatment and care costs are not restricted to any post accident period except where:

- the motor accident was caused wholly or mostly by the fault of the person and the person was over 16 years of age at the time of the motor accident, or
- the person's only injuries resulting from the accident were minor injuries;

and then treatment and care expenses incurred more than 26 weeks after the motor accident will not be payable in those circumstances.

Damages

Common law damages will be recoverable where an injury to another person is caused by the negligence of the owner or driver of the vehicle provided the only injuries suffered are not minor injuries.

However the damages recoverable are limited to economic loss and non economic loss (pain and suffering and loss of amenities of life) and non economic loss can only be awarded where the degree of permanent impairment of an injured person is greater than 10%.

If there is a dispute about whether the degree of permanent impairment of an injured person is sufficient for an award of damages for non-economic loss, or the degree of impairment of an injured person's earning capacity, a Court or Claims Assessor may refer a claimant for assessment by a medical assessor.

The certificate of a medical assessor is prima facie evidence of any matter certified as to the degree of impairment of earning capacity of the injured person as a result of the injury concerned, but conclusive evidence of any other matter certified, for example the degree of any permanent impairment. In any court proceedings, the court can reject a certificate as to all or any of the matters certified in it, on the grounds of denial of procedural fairness to a party but only if the court is satisfied that admission of the certificate as to the matter or matters concerned would cause substantial injustice.

When assessing damages consideration is to be given to the steps taken by the injured person to mitigate those damages and to the reasonable steps that could have been or could be taken by the injured person to mitigate those damages including undergoing medical treatment, undertaking rehabilitation, pursuing alternative employment opportunities, giving the earliest practicable notice of the claim in order to enable the assessment and implementation of treatment and rehabilitation.

Contributory negligence applies to the assessment of damages. There are prescribed circumstances where contributory negligence must be found for example where drugs or alcohol, or any failure to wear a

seatbelt or for motorcyclist helmet has been a factor in the accident or injury.

Disputes

There will be a new process for managing claims and dealing with disputes.

Where an insurer receives a claim and makes a decision a claimant may request an insurer to review any of the following decisions of the insurer made in connection with a claim (an internal review):

- a decision about a merit review matter;
- a decision about a medical assessment matter;
- a decision about a miscellaneous claims assessment matter

There are 27 decisions listed in Schedule 2 of the Act that are prescribed as merit review decisions, 5 medical assessment decisions and 13 miscellaneous decisions.

The Dispute Resolution Service ("DRS") will be established and will replace the Motor Accidents Claims Assessment and Resolution Service and the Motor Accidents Medical Assessment Service.

The DRS will establish:

- A system for independent medical assessment is for the resolution of disputes about degree of permanent impairment, treatment, impairment of earning capacity and other medical matters.
- A process for the merit review of the decisions of insurers.
- A process for the Assessment of Damages claims.

The DRS will appoint merit reviewers, medical assessors and claims assessors.

Where a claimant is dissatisfied with the decision of an insurer's internal review or the insurer fails to complete the review in the time required the claimant can file a merit review application with DRS and will give notice of the application to the insurer and a merit reviewer will be appointed by DRS and the merit reviewer will determine the issue and issue a certificate within 28 days. The Motor Accident Guidelines will establish the mechanisms for the process. The decision of the merit reviewer is binding on the parties subject to the claimant or an insurer applying to the proper officer of the Authority to refer a decision of a single merit reviewer determining a merit review application to a review panel of merit reviewers for review. Referral of a decision to a review panel may only be made on the grounds that the decision was incorrect in a material respect. The proper officer will refer the application to a panel of at least 2 merit reviewers, but only if the proper officer is satisfied that there is reasonable cause to suspect that the decision determining the review was incorrect in a material respect having regard to the particulars set out in the application.

A medical dispute about a decision of an insurer may not be referred by a claimant for assessment until the decision has been the subject of an internal review by the insurer.

A medical dispute about a claim may be referred to the DRS by either party to the dispute or by a merit reviewer, a claims assessor or a court.

The medical assessor or assessors to whom a medical dispute is referred is or are to give a certificate as to the matters referred for assessment and a certificate must set out the reasons for any finding by the medical assessor or assessors as to any matter certified in the certificate in respect of which the certificate is conclusive evidence.

A medical dispute referred for assessment may be referred again for assessment at any time by a court, a merit reviewer or a claims assessor. A claimant or the insurer will in some circumstances be entitled to refer the matter for assessment again but only once.

A claimant or an insurer may apply to the Proper Officer of the Authority to refer a medical assessment by a single medical assessor to a review panel of medical assessors for review on the grounds that the assessment was incorrect in a material respect. The Proper Officer acts as a gateway for the review.

A claim for damages may be referred to the Dispute Resolution Service by the claimant or the insurer, or both. A claims assessor will be appointed. Claims can be exempted from the assessment process. The claims assessor will make an assessment of the issue of liability for the claim (unless the insurer has admitted liability),and the amount of damages for that liability (being the amount of damages that a court would be likely to award.)

In making an assessment and specifying damages in respect of a claim, a claims assessor may include in the assessment an assessment of the claimant's costs (including costs for legal services and fees for medico-legal services).

In the assessment the assessor may have regard to the amount of any written offer of settlement made by either party to the matter, and must give effect to any requirement of the regulations fixing costs that may be included in an assessment or award of damages.

The assessor's determination on liability is not binding on any party however an assessment of the amount of damages for liability under a claim for damages is binding on the insurer, and the insurer must pay to the claimant the amount of damages specified in the certificate as to the assessment if the insurer admits that liability under the claim, and the claimant accepts that amount of damages in settlement of the claim within 21 days after the certificate of assessment is issued.

The Motor Accident Guidelines may make provision for or with respect to any aspect of procedures to be followed in assessments.

Claims assessors will have the power to give a direction in writing to a party to proceedings and to non parties to produce documents.

The Principal Claims Assessor will have power to issue a summons requiring the attendance of a party to an assessment at proceedings.

Legal Costs and Medico-Legal Costs

There will be an impact on the costs that can be charged by lawyers to claimants and lawyers.

The Regulations to the Act may:

- fix the maximum costs for legal services provided to a claimant or to an insurer in any motor accidents matter,
- fix the maximum costs for matters that are not legal services but are related to proceedings in any motor accidents matter (for example, expenses for investigations, for witnesses or for medical reports),
- declare that no costs are payable for any such legal services or other matters.

An Australian legal practitioner is not entitled to be paid or recover for a legal service or other matter an amount that exceeds any maximum costs fixed for the service or matter by the regulations. Essentially there can be no contracting out of the fixed costs regime.

An Australian legal practitioner is not entitled to be paid or recover legal costs for any legal services provided to a party to a claim for statutory benefits (whether the claimant or the insurer) in connection with the claim unless payment of those legal costs is permitted by the regulations or the Dispute Resolution Service.

The regulations may also make provision for or with respect to fixing maximum fees for the provision by health practitioners of any medical report for use in court proceedings in connection with a claim ,the provision of any medical report for use in the assessment of a claim, a medical assessment by a medical assessor or appearance as a witness in court proceedings, or in DRS proceedings.

Public Transport Accidents

The Motor Accidents Compensation Act 1999(“MACA”) which established the current CTP compensation regime will continue to apply until 1 December 2017.

The damages regime in the MACA also applies to an award of damages which relates to the death of or bodily injury to a person caused by or arising out of a public transport accident.

A "public transport accident" is an accident caused by or arising out of the use of any form of public transport in New South Wales, including public transport in the form of a passenger railway or a water ferry or taxi, but not including public transport in the form of air transport, or public transport that is operated primarily for tourists, the purposes of recreation or historical interest or that is an amusement device, or an accident for which, or to the extent to which, a person is liable otherwise than in the capacity of the owner or driver of, or other person in charge of, the vehicle or vessel used for public transport.

The Motor Accident Injuries Act (“MAIA”) preserves this position for accidents before 1 December 2017 and provides that the MACA will continue to apply to public transport accidents after 1 December 2017.

However the Government has power to make Regulations under the MAIA to apply provisions of the Motor Accident Injuries Act 2017 (with or without modifications) relating to the award of damages or statutory benefits to public transport accidents when it chooses to do so.

For now all public transport accidents will be subject to the MACA damages regime and claimants involved in public transport accidents will not entitled to statutory benefits under the MAIA.

Conclusions

The Act establishes a hybrid compensation scheme. It delivers statutory benefits for injured road users with injuries other than soft tissue or minor psychological injuries, regardless of fault, while retaining the right to claim modified common law damages for those with more than minor injuries that are able to establish fault.

The Act also addresses the costs of disputes by allowing the regulations to fix legal fees that injured people can be charged. It allows for both the fixing of maximum legal costs by reference to the amount recovered by the claimant and a fee-for-service model.

The new scheme will face challenges and disputes will remain a feature of the scheme however the Government hopes that the regime will ensure that 60 cents in every dollar of premium will return to injured road users, and every motorist will enjoy Greenslip premium relief.

David Newey
dtn@gdlaw.com.au

Driver of Forklift not the Owner’s Agent

Motor accident claims have a unique feature in negligence law involving the statutory presumption of agency which exists between the owner and driver of a motor vehicle pursuant to Section 112 of the *Motor Accidents Compensation Act 1999* (NSW) (“MACA”).

Relevantly, the section provides that the driver of a vehicle which is registered and for which a CTP policy is in force pursuant to Section 10 of the MACA, is the agent of the owner acting within the scope of the owner's authority in relation to the vehicle.

The agency relationship between the owner and driver of a motor vehicle means that the owner is liable for the negligent driving of the vehicle by the driver who causes personal injuries to a third party.

In a recent decision of the NSW District Court, her Honour Judge Gibson dismissed proceedings brought on behalf of a plaintiff who was involved in a forklift accident during the course of his employment when a co-worker forgot to apply the handbrake resulting in the forklift rolling down a slope and pinning the plaintiff's right foot, resulting in injury.

In *Macdonald v Inglis Equipment Pty Limited*, Graham Macdonald was employed by Dywidag-Systems International ("DSI") as a factory process worker near Newcastle.

Six months before the accident, Inglis entered into a hiring agreement with DSI whereby Inglis hired out a forklift to DSI for a period of five years.

As at the date of the hiring agreement and the date of accident, the forklift was subject to a conditional registration certificate issued pursuant to the *Road Transport Act 2013* (NSW).

Inglis was the registered owner of the forklift.

Macdonald made a claim against Inglis pursuant to the MACA provisions. He contended the circumstances gave rise to a motor accident claim for which Chapters 3 to 6 of the MACA applied.

The CTP insurer declined the claim on the basis that this was not a MACA claim.

Macdonald subsequently applied for an exemption from CARS which was granted by the principal claims assessor, despite the CTP insurer's contention this was not a motor accident claim.

When Macdonald filed a Statement of Claim at the District Court Newcastle, Inglis was sued as the sole defendant and the claim for damages was based entirely on the statutory presumption of agency pursuant to Section 112 of the MACA.

As such, Macdonald alleged that Inglis was liable for the negligent driving of the forklift by Macdonald's co-worker.

DSI, as the plaintiff's employer, was not sued in respect of its vicarious liability for the negligence of Macdonald's co-worker.

For Macdonald to succeed against Inglis, it was necessary for the plaintiff to establish that the statutory presumption of agency under Section 112 of the MACA applied, otherwise he would have no cause of action against Inglis.

Inglis filed a motion seeking orders to dismiss the proceedings with costs pursuant to Rule 13.4 of the Uniform Civil Procedure Rules 2005 (NSW) on the basis that the plaintiff had no cause of action and the proceedings were an abuse of process.

The motion proceeded before Judge Gibson.

Counsel for Inglis argued the statutory presumption of agency could not apply to these proceedings when considering the definition of "owner" in Section 4 of the MACA.

Section 4 of the MACA relevantly provides that the owner of a vehicle is no longer the "owner" if the vehicle is hired out for a period of no less than three months, in which case the party who has hired the vehicle becomes the "owner" within the meaning of the MACA.

As Inglis had ceased to have possession of the forklift six months before the accident, pursuant to the hiring agreement between Inglis and DSI, Counsel for Inglis submitted that DSI became the "owner" of the vehicle within the meaning of Section 4 of the MACA and therefore the statutory presumption of agency pursuant to Section 112 of the MACA could not apply as between Inglis and the driver of the forklift who caused Macdonald's injuries.

Judge Gibson agreed.

Her Honour observed that the plaintiff's claim, predicated as it was on the statutory presumption of agency, was doomed to fail.

Counsel for the plaintiff then made a verbal application for leave to file an Amended Statement of Claim during the hearing of the defendant's motion to dismiss.

That application was also refused by her Honour.

Judge Gibson found that the proposed Amended Statement of Claim did not properly plead and particularise the new allegations that were sought to be made against Inglis regarding an alleged failure by Inglis to exercise reasonable care with respect to the repair, servicing and maintenance of the forklift.

Accordingly, Judge Gibson dismissed the plaintiff's proceedings against Inglis with an order for costs against the plaintiff.

This case demonstrates that in certain circumstances, the "owner" of a vehicle under the MACA legislation is not necessarily the registered owner of the vehicle particularly in circumstances where the vehicle has been hired out to another party for more than three months, in which case the registered owner ceases to have possession of the vehicle and the hiring party becomes the owner.

One can envisage numerous cases involving forklift accidents where this situation may well arise.

It is a timely reminder for insurers to consider the operation of these provisions under the MACA

legislation in circumstances where an injured plaintiff intends to sue only the registered owner of the vehicle by adopting the statutory presumption of agency which may not apply as highlighted by Judge Gibson in the above decision.

In this case, the Court found that Inglis could not be found liable for the negligent acts of the driver of the forklift as at the date of accident. Accordingly, the plaintiff's Statement of Claim did not disclose a cause of action against Inglis and the proceedings were dismissed with costs.

Darren King
dwk@gdlaw.com.au

Court Refuses Leave to Join Insurer

Section 6 of the *Law Reform (Miscellaneous Provisions) Act 1946* (NSW) ("LRMPA") enables a third party to apply to join an insurer to proceedings where an insured of that insurer relevantly held a policy of insurance which responds to the claim and where there is evidence the insured would be unable to satisfy a judgment against him or her.

More often than not, NSW Courts will allow an insurer to be joined in circumstances where there is a fairly arguable case that the policy responds to the claim and that the insured may, if sued, have been found liable.

However there are instances where the Court will refuse to grant leave to join the insurer under Section 6 of the LRMPA.

This was recently illustrated in *Wayland v Bird* in which the NSW Court of Appeal unanimously refused leave to appeal from a decision of her Honour Judge Olsson of the District Court where her Honour had refused leave for the plaintiff to join the professional indemnity insurer of an expert who provided a pest inspection report prior to the purchase of a property.

Mr and Mrs Wayland owned property at Wyongah.

Prior to the purchase of the property, the Waylands obtained a pest inspection report from Daniel Bird.

The Waylands commenced proceedings at the District Court against Bird claiming damages for negligence and breach of contract in relation to that report and pest control services allegedly provided by Bird after purchase.

The claim involved allegations of property damage claimed to have been sustained by the presence of termites undetected in the pest inspection.

Bird took no part in the District Court proceedings and did not file a Defence.

The Waylands then filed a motion seeking leave under Section 6 of the LRMPA to join Pacific International Insurance Limited as the professional indemnity insurer of Bird.

The evidence led at the hearing of the Waylands' District Court motion revealed Bird's insurer had been notified of the claim by the Waylands but despite repeated efforts by the insurer to obtain information from Bird regarding the claim, Bird provided little or no cooperation and indeed he did not make a claim on his policy regarding the Waylands' proceedings for damages.

After several attempts to elicit the information from Bird about the claim, the solicitors for the insurer International wrote to Bird advising him they withdrew their representation of him and an earlier decision by the insurer to grant indemnity in respect of the claim was revoked.

Further, evidence of real property searches carried out three years before the hearing of the motion showed that Bird held no real property in New South Wales. There was no recent evidence of similar searches before the District Court.

Judge Olsson dismissed the Waylands' application for leave to join the insurer as a defendant to the proceedings. Her Honour held:

> *"I am satisfied that the conduct of the defendant has caused such prejudice to the insurer that it is entitled to refuse indemnity to him. That being the case, Section 6 of the LRMPA is not enlivened. I should also add that in any event, I am not satisfied that there is a real possibility that the defendant would be unable to meet any judgment. There is no evidence of his financial circumstances. The title searches are not current and in any case are ambiguous. On the other hand, there is evidence that he is still operating his business and there is some evidence that implies that he intends to stay in business. His behaviour in refusing to make a claim on his policy and in refusing to participate in proceedings might seem to some to be perverse, but is not evidence of impecuniosity".*

The Waylands applied for leave to appeal from her Honour's judgment at the NSW Court of Appeal.

By a unanimous judgment (Ward JA, MacFarlan JA and Emmett AJA agreeing), the Court of Appeal refused leave to appeal.

At the hearing of the application for leave to appeal, it was submitted on behalf of the Waylands that the primary judge erred by not applying established principles for the grant of leave to join insurers pursuant to Section 6 of the LRMPA.

Specifically, it was contended for the Waylands there was no evidence of prejudice or sufficient prejudice such as to refuse leave to join the insurer.

Her Honour Justice Ward who wrote the leading judgment held:

> *"In the present case, there was no dispute that the applicants had established on the balance of probabilities that there was an arguable case against Bird and there was an insurance policy that responded to that claim. There was a dispute as to whether the evidence established that there was a real possibility that Bird would be unable to satisfy a judgment made against him".*

Later, her Honour observed:

> *"However, while those are matters which must be established before such an order will be made, the establishment of each of those matters does not mandate the making of such an order. That question remains one within the discretion of the Court".*

The Court of Appeal agreed the insurer had suffered prejudice by reason of Bird's failure to respond to specific requests for information and documentation such that any lawyer acting for the insurer would not be in a position to file a Defence which could be properly certified regarding the reasonable prospects of that defence succeeding.

Further, the Court held that the primary judge had correctly turned her mind to the question of prejudice as part of the weighing of relevant factors to the exercise of her discretion such that no error had been demonstrated by the Waylands.

Ward JA concluded:

> "*In the present case, the amount in issue is relatively small; there are avenues open to the applicants to pursue their claim against Bird and, if successful, to take steps to enforce it; the applicants are not shut out from claiming in that event against the insurance policy and hence no substantial injustice in the refusal of leave to join the second respondent to the proceedings has been shown*".

Accordingly, the Court of Appeal refused leave to appeal and the Waylands were unsuccessful in joining Bird's professional indemnity insurer to the proceedings.

This case demonstrates the circumstances which may arise to establish that the prejudice suffered by an insurer from the insured's failure to cooperate and provide relevant information may well result in an insurer successfully resisting an application to be joined to proceedings under Section 6 of the LRMPA.

Although the Court of Appeal emphasised that evidence of such prejudice is not determinative of an application for leave, it will be highly relevant where there is insufficient evidence to establish that the insured would be unable to meet a judgment, as was the case here.

In this case, the Court of Appeal agreed that the primary judge had correctly exercised her discretion to refuse leave to join the insurer.

Darren King
dwk@gdlaw.com.au

Is PTSD a bodily injury?

Post traumatic stress disorder ("PTSD") is a recognised psychiatric illness, the criteria for which are set out in the Diagnostic and Statistical Manual of Mental Disorders ("DSM-V).

The diagnostic criteria for PTSD include a history of exposure to a traumatic event which meets specific stipulations and symptoms such as intense or prolonged distress after exposure to traumatic reminders and flashbacks which may occur from brief episodes to complete loss of consciousness.

In a recent NSW Court of Appeal decision, the Court considered whether or not PTSD constituted a "bodily injury" in the context of a claim for damages brought by an injured plaintiff pursuant to the *Civil Aviation (Carriers' Liability) Act 1959* (Cth), who survived a plane crash and suffered significant injuries.

In *Pel-Air Aviation Pty Limited v Casey*, Karen Casey was a nurse employed by Care Flight (NSW) who travelled on a small aircraft to Samoa to evacuate a patient and her husband to Melbourne.

On the return journey, bad weather prevented the pilot from conducting a scheduled refuelling stop at Norfolk Island, as a result of which he ditched the aircraft at sea.

All six persons on board the aircraft were rescued after spending about 90 minutes in the water.

Casey suffered significant physical injuries including spinal injuries and in addition she developed PTSD.

Proceedings were initially commenced in the NSW District Court but later transferred to the Supreme Court.

Casey's claim for damages against Pel-Air, the aircraft carrier, was governed by the *Civil Aviation (Carriers' Liability) Act* which gives the Montreal Convention the force of law in Australia.

At first instance, Casey was successful and had a judgment entered in her favour in the sum of $4,877,604.00.

Pel-Air appealed to the NSW Court of Appeal. The primary issue for the Appeal Court's consideration was whether or not PTSD constituted a bodily injury within Article 17(1) of the Montreal Convention which is in the following terms:

"The carrier is liable for damage sustained in case of death or bodily injury of a passenger upon condition only that the accident which caused the death or injury took place on board the aircraft or in the course of any of the operations of embarking or disembarking".

At first instance her Honour Justice Schmidt held that:

"A diagnosis of PTSD does not exclude the possibility that evidence in a particular case may establish that a person has suffered a bodily injury compensable under the Montreal Convention. The PTSD which Ms Casey suffers and for which she has also been unsuccessfully treated, is consequent on damage to her brain and to other parts of her bodily processes, which have had the result that her brain is no longer capable of functioning normally".

Accordingly, the Primary Judge held that PTSD constituted a "bodily injury" for the purpose of the Montreal Convention as applied in Australian law by Section 9B of the *Civil Aviation (Carriers' Liability) Act*.

On appeal, Pel-Air submitted that the legal authorities did not justify a conclusion that any change in bodily condition or function was sufficient to constitute "bodily injury" within the meaning of the Convention and further, if her Honour's judgment involved a conclusion that the evidence before her indicated that Ms Casey's PTSD was the manifestation of some damage to her body, that conclusion was erroneous.

The Court of Appeal considered earlier decisions of the NSW Court of Appeal and decisions from the United States of America involving injuries under the Montreal Convention, specifically injured persons who have developed PTSD.

By a unanimous judgment, the NSW Court of Appeal allowed Pel-Air's appeal on this issue.

Justice MacFarlan wrote the leading judgment (with whom Ward and Gleeson JJA agreed).

His Honour observed that the expression "bodily injury" connotes damage to a person's body but there is no reason to regard this as excluding consideration of damage to a person's brain. Thus, if the evidence in a particular case demonstrates there has been a physical destruction of a part or parts of the brain, "bodily injury" will have been proved.

McFarlan JA then stated:

"… In the present case, there was no proof that Ms Casey's PTSD resulted from actual physical damage to her brain. However the more difficult question that arises is whether the biochemical changes in her brain, of which there is evidence in the present case, constitute 'bodily injuries'. My conclusion is that they do not".

Justice McFarlan held:

"I consider that it is insufficient for a claimant to prove that the function of his or her brain has changed or even that chemical changes have occurred in it. In the absence of compelling medical evidence to the contrary, such malfunctioning or chemical changes cannot fairly be described as 'injuries' to the body. Moreover, importance must be attached to the adjective 'bodily' as a limiting word. It clearly draws a distinction between bodily and mental injuries: mental injuries are covered only if they are a manifestation of physical injuries, or if they result from physical injuries (including physical injuries to the brain)".

The NSW Court of Appeal held that the primary judge's conclusion that Ms Casey's PTSD was a bodily injury because normal functioning of her brain was impaired was, in the absence of evidence of physical damage to the brain, erroneous.

This interesting judgment reveals the distinction made by the Courts between a bodily injury and a mental illness which may or may not arise from bodily injury sustained in an accident.

Here, the Court highlighted the evidence of loss of function of the brain and resulting PTSD was insufficient to establish bodily injury in the absence of actual destruction of the brain.

Although the distinction was drawn in the circumstances involving the survivor of a plane crash where the governing legislation is more restrictive, the Court's decision illustrates an interesting interpretation of the relevant section which, according to the Court of Appeal, excludes claims for PTSD.

Darren King
dwk@gdlaw.com.au

Labour hire employer liable

In recent editions of GD News we have reported on decisions of the Courts involving the apportionment of liability between the direct employer and host employer in a labour hire scenario.

The general trend which has developed usually results in the host employer bearing the lion's share of liability with the direct employer bearing a minor share, often as little as 10-20% liability with some situations resulting in the host employer being found wholly liable.

In a recent decision of His Honour Judge Levy SC of the District Court of NSW, His Honour considered the apportionment of liability between a direct employer and host employer where the direct employer was not sued by the injured plaintiff and the defendant had pleaded a Defence pursuant to the *Workers Compensation Act 1987* (NSW) ("WCA");

Section 151Z(2) in respect of the direct employer's negligence.

In *Livermore v Nepean Longwall Pty Limited*, Mrs Lourdelyn Livermore was employed by a labour hire company, Maxwell Recruitment Pty Limited ("Maxwell") and on the day of her injury she was assigned to work at premises owned and occupied by Nepean Longwall Pty Limited ("Nepean") as a trades assistant in a work process involving repair and maintenance of heavy mining equipment known as roof chocks.

Immediately before her injury occurred, Livermore was standing at ground level next to a roof chock on which maintenance work was being performed by another employee, Geoffrey Guest. Livermore was assisting Guest by handing him maintenance tools whilst he was standing in an elevated position on a stool located on a steel section of the roof chock.

The evidence led at the hearing established that the surface of the area upon which the stool was located had been contaminated by hydraulic fluid which had flowed down from the roof chock during the disassembly process thereby rendering the surface slippery.

Guest lost his foothold and slipped when the stool on which he was standing moved, resulting in him falling backwards onto the plaintiff who was standing below and nearby.

Livermore brought proceedings in the District Court but only against Nepean. Her claim for damages against Nepean was governed by the *Civil Liability Act 2002* (NSW) ("CLA").

Livermore was unable to bring a work injury damages claim against Maxwell, her employer, because her injury did not overcome the 15% whole person impairment threshold.

Nepean was sued on the basis it was the host employer exercising control in relation to Livermore's work activities.

Nepean filed a Defence raising Section 151Z of the WCA and sought a reduction in any damages to be awarded to Livermore by reason of Maxwell's negligence as her direct employer.

The matter proceeded to hearing before His Honour Judge Levy SC of the District Court.

Evidence was given by Livermore and Guest, and Livermore relied on expert evidence from David Dubos. The expert was not required for cross examination.

His Honour accepted Livermore was a witness of truth and noted the expert evidence tendered on her behalf was largely unchallenged.

The trial judge found that, as host employer, Nepean was in control of the system by which the work involving maintenance on the roof chocks should be undertaken.

Accordingly, Judge Levy found Nepean had a duty of care towards onsite workers such as Guest and Livermore which required Nepean to address foreseeable risks of harm emerging in its operations at the site.

Further, His Honour noted the required precautions that ought to have been taken by Nepean involved little more than the exercise of common sense in light of the very significant risk of injury that arose when persons in the position of Guest were required to place their weight on surfaces which would in the course of required work become contaminated by hydraulic fluid.

Accordingly His Honour had no difficulty in finding Nepean was negligent under the CLA.

Pursuant to Section 151Z of the WCA, Nepean argued for a 20% reduction regarding Maxwell's negligence and His Honour noted that Livermore's Counsel accepted that submission.

Although the parties had effectively agreed on an appropriate reduction for Maxwell's negligence, His Honour held that the liability analysis and safety criticisms provided in the expert evidence of Dubos applied equally to Nepean and Maxwell such that Maxwell was clearly negligent in breaching its non delegable duty of care to Livermore.

The result was that the plaintiff was entitled to damages against Nepean in the sum of $322,738 but those damages were reduced by 20% to account for the negligence of Maxwell as Livermore's direct employer.

Accordingly, Judge Levy entered judgment in favour of Livermore in the sum of $258,190.

This case illustrates the operation of the defence of Section 151Z(2) WCA in circumstances where the direct employer is not a defendant in proceedings brought by the injured plaintiff.

Assuming the defendant/host employer can establish the direct employer was also negligent, the damages awarded to the injured plaintiff will be reduced by the appropriate percentage liability attaching to the direct employer.

In this case the host employer was found 80% liable and the direct employer 20% liable. This is in keeping with the trend which has developed in Court decisions involving labour hire employees.

Darren King
dwk@gdlaw.com.au

CONSTRUCTION ROUNDUP

Service of formal documents by USB stick not acceptable – can legislation ever really catch up with modern technology?

With the convenience and speed of sending information in electronic form, it is easy to assume the service of formal legal documents electronically is, in modern times, acceptable and compliant with the requirements of legislation. However, as illustrated in the recent NSW Supreme Court decision of *Parkview Constructions Pty Limited v Total Lifestyle Windows Pty Limited t/as Total Concept Group* [2017] NSWSC 194, this is not necessarily so. This case also highlights the importance of triple-checking the documents which are served on other parties.

Parkview had been constructing a high rise residential development at Woolooware Bay, New South Wales. They had engaged Total to design, supply and install glazed windows and doors at the development. On 11 October 2016 Total had served a payment claim for $668,177.24 including GST under the *Building and Construction Industry Security of Payment Act 1999* (NSW). On 25 October 2016 Parkview had responded with a payment schedule which disputed Total's entitlement to any payment at all.

The deadline for Total to make an adjudication application under the process of the Act was 8 November 2016. This process includes sending to an authorised nominating authority an application form and all documents on which the contractor wishes to rely in support of its claim. Total made its application to ABC Dispute Resolution Service, which uses the service of an internet based data storage provider called Hightail. Similar to Dropbox or One Drive, Hightail enables users to upload, share and download files via a web browser or desktop application and such files can be shared by sending other people an access link via email.

Total had prepared an adjudication application which had comprised four lever arch folders and included submissions, witness statements and supporting documentation. On 8 November 2016 Total had uploaded the adjudication application to ABC's space on Hightail and had provided to ABC a link to the uploaded files. However, later the same day Total had separately uploaded a further, revised version of its submissions.

Total had "pasted" a copy of the application to a USB stick. This stick together with a covering letter was sent by pre-paid Express Post envelope to Parkview's physical address in Pyrmont in New South Wales. The covering letter noted that a hard copy of the application would be sent by courier to Parkview's office later the same week.

During this process, Total's adjudication application had been affected by a number of significant errors. The first error was that the version of the application that was uploaded to Hightail did not include the witness statements.

The second error was that the hard copy version of the adjudication application which Total had provided to ABC two days later had not contained the revised submissions but only the original submissions. They had however contained the witness statements.

The third error was that the version of the application ABC forwarded to the adjudicator had not included the revised submissions but only the original ones. It transpired that the revised submissions had never been given to the adjudicator and the original submissions had never been given to Parkview.

The fourth error was that the folders received by the adjudicator had contained some documents that had not been included on the USB stick and vice versa.

Under the provisions of the Act, Parkview had been required to serve its response to the adjudication application within five business days after receiving a copy of the application. There was a dispute between the parties as to when precisely Parkview had received a copy of the adjudication application – was it on 9 November when it had received the USB stick or was it on 11 November when it had received the hard copy of the four volumes of documents?

After inviting further submissions from the parties, the adjudicator had determined that the adjudication application had been served on Parkview on 9 November upon delivery of the USB stick and accordingly he had disregarded Parkview's adjudication response which (in his view) had been served too late. He had determined that Total was entitled to be paid $539,634.24 including GST.

Parkview commenced proceedings in the Supreme Court applying for an order that the adjudication be declared void or be quashed on the grounds that a true copy of the adjudication application had never been provided to Parkview and that the adjudicator had denied Parkview procedural fairness by refusing to consider Parkview's adjudication response.

In deciding the matter Justice Hammerschlag carefully examined the chronology of Total's actions and the documents that had been provided to the various parties. His Honour described the course of events as a "litany of errors". In his Honour's view, the errors in the process were significant and had infected the adjudication application.

Justice Hammerschlag noted that section 17(5) of the Act makes it a mandatory requirement that a copy of the adjudication application be served on the respondent. In this regard his Honour commented that the use of the word "copy" in that section made it clear that the written words which constitute the adjudication application are to be communicated to the respondent.

Further, his Honour noted that it is *the* adjudication that had been made to the authorised nominating authority which must be served on the respondent. His Honour expressed declined to consider the situation of where the copy of the adjudication application served on the respondent had trivial differences, noting that in the current case he was being asked to consider differences that were far from trivial. In this regard his Honour noted that the adjudicator had based his determination on information which had not been included in one of the versions of the adjudication application and therefore the omission of these documents or this information was significant.

His Honour identified that a further significant issue was whether delivery alone of USB stick (in other words without providing documents in hard copy form) constitutes service of something in writing for the purposes of the Act. His Honour stated that in his opinion delivery of a USB stick is not to be equated with service of the writing that is stored on that USB stick. He explained that in order to access what is stored on the USB stick, the recipient must first take the step of accessing, opening and viewing the files stored on it. To access information on a USB stick the recipient must have compatible technology and this cannot be regarded as an inevitability, even today.

Accordingly, the Court quashed the adjudication determination in this case.

To those of us who have been sent documents on an internet based data service provider such as Hightail, Dropbox or One Drive and have had problems with accessing those files, Justice Hamerschlag's decision resounds with common sense. However, in practical terms it will mean that parties will continue to be required to print, collate, copy and courier often voluminous documentation within an extremely short space of time in order to satisfy the requirements of the Act – which many people would view as a rather antiquated way of conducting business dealings in the modern world.

As governments and legislation race to catch up with the advances of modern technology it will be interesting to see if the meaning of "writing" in the *Interpretation Act 1987* (NSW) is updated in the near future to accommodate electronic forms of communication that are conveyed through the "cloud".

Linda Holland
lmh@gdlaw.com.au

Sequestration to enforce adjudication judgments

It is not uncommon that when a Court orders a party to pay a substantial amount of money to the other, the party ordered to pay the money may try to relocate assets so that they cannot be recovered as part of the judgment.

One approach which the party trying to recover the judgment sum might use to try to recover assets is applying to the Court for sequestration. Sequestration effectively orders a seizure of the person's property until they pay the judgment debt or until a further order from the Court.

The case of *TJ & RF Fordham v Starhill Property Group Pty Limited* involved an ex parte application for a Writ of Sequestration following a successful adjudication judgment in the plaintiff's favour.

The matter was heard by Justice Campbell.

The plaintiff, TJ & RF Fordham, was a contractor hired by the defendant, Starhill Property Group, in relation to a project known as "Civil Works, Park View Project, Spring Farm". The matter went to adjudication and judgment was entered against Starhill in the sum of $2,968,858.30.

At the time of the adjudication, the controlling director and effective mind of Starhill was a man named Mr Tan.

Mr Tan's main asset at the time of the adjudication judgment was the property known as Spring Farm on which the development was being completed.

The judgment was entered on 7 March 2017 by way of filing of an adjudication certificate under the *Building and Construction Industry Security of Payment Act 1999* (NSW).

Shortly after the filing of the adjudication certificate it became apparent Mr Tan had sold the property. Settlement of the property had taken place on 8 March 2017, just one day following the filing of the adjudication certificate.

TJ & RF Fordham made an ex parte application to the NSW Supreme Court for a Writ of Sequestration in an attempt to recover as much of the judgment sum as possible.

His Honour noted a variety of suspicious conduct surrounding the sale that raised concern beyond the fact of the settlement date being the day after the day of registration of the judgment.

It was noted that the purchaser spoke with the solicitors for TJ & RF Fordham on 9 March 2017. The purchaser told the solicitors that the transaction was at arm's length although he wouldn't divulge how much Starhill were paid.

His Honour noted that the purchaser and vendor appeared to have been associates at the time of the sale.

There was clear evidence that Mr Tan had been informed by his former solicitor in an email on 9 March 2017 that judgment had been entered but there had been no response to that email. That email advised

against displacement of any assets and also enclosed a property search indicating the Spring Farm property had already been sold.

TJ & RF Fordham's solicitor had also tried to contact Mr Tan by way of landline phone. A person with an Asian accent answered the phone on 9 March 2017 and stated that Mr Tan was not in the office and they would take a message. The solicitor never received a return call from Mr Tan.

His Honour was convinced that these facts when read together suggested a real risk that Mr Tan was intentionally avoiding fulfilment of the judgment sum. As such, His Honour was content to deal with the matter on an ex parte basis and to issue a Writ of Sequestration.

His Honour agreed to the appointing of professional insolvency practitioners having reviewed their fee schedules and being satisfied those rates were appropriate.

This case highlights that relocating assets or avoiding contact from the other party in an attempt to evade a judgment is unlikely to be successful.

Victoria Upton
vmu@gdlaw.com.au

EMPLOYMENT ROUNDUP

Reinstatement of Injured Workers – Reason for Dismissal is Crucial

In NSW Part 8 of the *Workers Compensation Act 1987* empowers an injured worker to apply for reinstatement if they are terminated due to a work injury and not some other reason. Distilling the reasons for termination is not always easy. However, where the reason for termination is unrelated to the work injury reinstatement will not be granted as was seen in the Industrial Relations Commission ("IRC") decision of *Schobbe v ANZ Banking Group* (2017) NSWIRComm 1005.

The claimant, Catherine Schobbe, made an application to the Commission pursuant to Section 242 of the *Workers Compensation Act 1987* for an order reinstating her to the position of personal banker with her employer, The ANZ Banking Group Limited. Schobbe commenced employment with ANZ as a full time service consultant in 2006. After a period of maternity leave she returned to work in March 2010 working 21 hours per week. Schobbe took extended periods of absence and sick leave due to a variety of causes throughout 2013 including absences caused by a motor vehicle accident.

In early 2014 Schobbe took further sick leave but failed to provide medical certificates either at all or in a timely manner. She also failed to record her absences in the manner as directed by ANZ.

On 1 April 2014 Schobbe was issued with a final warning letter due to her failure to comply with a reasonable direction with respect to ANZ's sick leave policy. Annexed to the letter was an attachment which set out a number of directions which Schobbe was required to follow when taking sick leave. Between the issuing of the final warning on 1 April 2014 and 4 September 2014 Schobbe took approximately 50 days leave, mostly as leave without pay. Schobbe continued to fail to comply with the directions which had been provided to her in her final warning letter of 1 April 2014.

On 16 September 2014 ANZ requested Schobbe attend a formal meeting to discuss her absences from work. Schobbe was provided with a list of eight allegations concerning times when she had been absent from work and failed to comply with earlier directions concerning notification to her branch manager. Schobbe claimed she had never received the attachment to the final warning letter and ANZ formed the view she had received the attachment and her claim to the contrary was dishonest.

A further meeting was convened in order to provide Schobbe with an opportunity to respond to the allegation she had been dishonest in relation to the attachment and the meeting was reconvened on 22 September 2014 when her employment was terminated due to a failure to comply with reasonable directions as to compliance with the expectations set out in her warning letter and dishonesty in relation to her responses about receiving the attachment as part of the final warning letter.

Importantly, at the time of Schobbe's dismissal she made no claim she was not fit for work as a result of a work related injury or any other reason.

On 3 October 2014 Schobbe lodged a worker's compensation claim alleging psychological injury and seeking weekly compensation and lump sum compensation. The claim was initially denied by ANZ however it was ultimately settled in March 2016 with payment of a closed period of weekly compensation.

On 30 June 2016 Schobbe obtained a medical certificate from her treating doctor who declared her fit for her pre-injury duties and she made an application to the IRC for reinstatement on the basis she was fit for her pre-injury duties.

The IRC determined the application failed to satisfy the requirement in Section 241 of the *Workers Compensation Act 1987* in that Schobbe was not dismissed as a result of a workplace injury. ANZ had rebutted the presumption Schobbe was dismissed as she was not fit for employment as a result of a workplace injury. The Commission was satisfied the

dismissal of Schobbe had nothing at all to do with the work related psychological injury which Schobbe claimed to have suffered. As at 22 September 2014, the day on which the decision was made to dismiss Schobbe, there was no suggestion from her she was not fit for employment as a result of a work related injury or any other reason. The substantive substantial and operative cause of the dismissal was her failure to comply with reasonable directions by her employer and her dishonesty.

Even though on 7 March 2016 the parties settled Schobbe's workers compensation claim and agreed on a deemed date of injury of 15 September 2014, this could not alter the state of mind of the ANZ decision makers as at 22 September 2014, the date on which Schobbe was dismissed. Quite simply, her psychological injury for which she ultimately received workers compensation payments played no part whatsoever in the dismissal of Schobbe.

This decision will provide some comfort to employers who dismiss workers for reasons unrelated to a worker's compensation injury. Even if a worker's compensation claim is later made by the employee and workers compensation benefits are paid to the employee, providing the employer had no knowledge at the time of the dismissal of a work related injury any application for reinstatement will be dismissed irrespective of whether the employee is fit to return to their pre-injury duties.

Stephen Hodges
sbh@gdlaw.com.au

WORKERS COMPENSATION ROUNDUP

Parliamentary Review into the Workers Compensation Scheme

Hot on the heels of the sweeping changes being made to the Motor Accidents Compensation Scheme, the NSW Parliament Standing Committee on Law & Justice has released its first review on the NSW Workers Compensation Scheme.

The two predominant themes arising from the review are a lack of transparency and the unwieldy nature of the dispute resolution process faced by injured workers.

Twenty six recommendations were provided by the committee and a large number of the recommendations provide for greater transparency in the workers compensation scheme. This includes the development of a number of guidelines for the use of rehabilitation, issuing guidance notes to nominated treating doctors about their legal obligations in workers compensation matters and a guidance note as to the pre-approval of medical expenses.

The second theme, following on from a number of submissions from various groups, is to highlight the current unwieldy nature of the dispute process for injured workers. A primary recommendation was to further investigate the removal of the distinction between work capacity decisions (subject to merit review with Workers Compensation Independent Review Office – WIRO) and liability decisions which are determined in the Workers Compensation Commission.

In the alternative, consideration should be given to the introduction of a single notice for both work capacity decisions and liability decisions made by insurers.

To further streamline the dispute process, a recommendation has been made for the establishment of a "one stop shop" forum for resolution of all workers compensation disputes through the use of properly qualified judicial officers where appropriate and making use of technology to support the settlement of a small claim. Noting the proposed introduction of the dispute resolution service in the Motor Accidents Compensation Scheme, a further recommendation is for development of a more comprehensive specialised personal injury jurisdiction in New South Wales to deal with both disputes in workers compensation and motor accidents.

The Committee also directed some criticism to the case management process used by workers compensation Scheme Agents and a recommendation was made for a single comprehensive qualification and training network for all case managers incorporating specific skills to identify and deal with mental health issues. The Committee expressed their disappointment to receive evidence suggesting that Scheme Agents are not adequately supporting injured workers and in some instances, not appropriately following guidelines issued by the Regulator especially in relation to use of surveillance, independent medical examiners and nominated treating doctors. A sanction was proposed for Scheme Agents who fail to comply with applicable guidelines including mandatory surveillance guidelines, penalties for Scheme Agents who exert undue pressure on nominated treating doctors and inappropriate use of independent medical examiners.

Interestingly, despite the committee finding the Scheme is now $1.87 billion in surplus, there appears to be no substantive changes proposed to the legislation to increase the level and duration of benefits to be provided to injured workers. The only substantive change appears to be the possibility of amending the legislation to allow up to two assessments of permanent impairment for certain clearly defined injuries that are prone to deteriorate over time (such as spinal injuries) instead of the current single assessment.

The NSW Government is to report to the committee by September 2017 as to any proposed changes following the recommendations. Although there is little prospect of substantive changes to restore the compensation removed from injured workers in the 2012 amendments, the recommendation for an independent judicial one stop shop for workers compensation disputes, especially when coupled with the changes to the Motor Accidents Compensation Scheme, certainly provides impetus for a "back to the future" approach for a judicial forum that existed prior to 2002. The access to injured workers and Scheme Agents of experienced legal representation with the right to appeal to a superior Court, coupled with a streamlined dispute process, makes sense from both a financial and access to justice perspective.

Stephen Hodges
sbh@gdlaw.com.au

Reasonable actions by an employer - a medical question not just a factual one!

For an employer to succeed in a defence based on Section 11A(1) of the 1987 Act in psychological injury claims it must prove the injury was "wholly or predominantly" caused by reasonable action taken or proposed to be taken with respect to one of the eight actions specified in the section. The recent Presidential decision in *Hamad v Q Catering Limited* [2017] NSWWCCPD 6 has highlighted the imperative to obtain expert medical evidence specifically linking the psychological injury to reasonable actions relied upon by the employer when there are possible multiple causes for the injury.

Mr Hamad was employed by Q Catering as a level 5 leading hand in consolidation (assembly) of aircraft meals from 1999. In 2013 those duties were amalgamated with the duties of level 5 leading hands to include the transferring food to aircraft and handover to the flight crew. An issue developed involving the Transport Workers Union regarding the level of entitlement paid to leading hands performing the combined role. From February 2015 the leading hands declined to continue performing the transport tasks of the combined role.

As a result Mr Hamad was given a letter of direction to perform the combined role at a meeting on 19 February 2015. On advice from the Union, Mr Hamad declined to take the letter which was then sent to his home by post.

The following day Mr Hamad again declined to carry out the combined role. He was called to a meeting with his immediate manager and the business manager, accompanied by a support person from the Union. Mr Hamad was given a letter of warning for failure to follow a reasonable and lawful direction together with a copy of the Standards of Conduct and a performance improvement plan.

At 3:15pm that day Mr Hamad was paged and required to complete the meals for a flight which was due out in less than two hours as the meals had not been prepared earlier due to an oversight. Mr Hamad considered these duties to be "inferior" duties and amounted to a downgrade from Grade 5 to Grade 1 duties and thus he considered he was being discriminated against.

Mr Hamad ceased work at the end of his shift and came under the care of his general practitioner and a psychiatrist.

Liability for the injury was disputed and the employer relied upon a defence under Section 11A(1) of the 1987 Act relying on its reasonable action with respect to performance appraisal and discipline.

At the arbitration the employer conceded the occurrence of a psychological injury but maintained its defence on the basis of Section 11A(1). The arbitrator accepted the meeting on 20 February 2015 at which Hamad was given a warning letter was "discipline" within the meaning of Section 11A(1).

The arbitrator determined the psychological injury was predominantly caused by disciplinary action taken by the employer in meeting with him and handing him a warning letter. He accepted the provision of a warning letter was reasonable disciplinary action as the conduct of the worker was contrary to the terms and conditions of his employment. He entered an award in favour of the employer.

Mr Hamad lodged an appeal on the basis the arbitrator erred in finding the injury was wholly or predominantly caused by disciplinary action when there was no expert medical evidence dealing with the issue that the injury was wholly or predominantly caused by the relevant action taken or proposed to be taken by the employer. Furthermore Mr Hamad alleged that the employer's conduct was not reasonable and the arbitrator took into account irrelevant considerations.

In determining the appeal Deputy President Michael Snell stated:

> *"The causal test in Section 11A(1) is 'different, and more difficult', in that the test does not involve proof of 'personal injury arising out of or in the course of employment' (the Section 4(a) test), or that employment was a 'substantial contributing factor' to the injury (the Section 9A test), but rather whether the injury was 'wholly or predominantly caused' by the relevant action. It is to be proved on the balance of probabilities: normal principles governing proof of causation apply, but subject to the fact that what must be established is a different statutory test to those in ss 4 and 9A and the onus falls on the employer, rather than the worker".*

He agreed the arbitrator was entitled to rely on his "commonsense evaluation of the sequence of events" and make commonsense findings provided these were "within the realm of common knowledge and experience".

The only medical evidence tendered in the case relevant to the issue of causation was from Mr Hamad's treating and qualified doctors. The employer did not adduce any medical evidence. The Deputy President observed the available medical evidence on causation suggested there were potential causal factors beyond the warning letter and disciplinary interview on 20 February 2015. He then observed:

> *"The extent to which aspects of the appellant's history contributed to causing psychological injury was not, in the circumstances, something which could be decided in the absence of medical evidence. There may be cases in which causation of a psychological injury can be established without specific medical evidence, for example where there is a single instance of major psychological trauma with no other competing factors. The need for medical evidence, dealing with the causation issue in Section 11A(1) of the 1987 Act, will depend on the facts and circumstances of the individual case. In the current case, as in most, there are a number of potentially causative factors raised in the appellant's statement and the medical history. Proof of whether those factors, which potentially provided a defence under Section 11A(1), were the whole or predominant cause of the psychological injury, required medical evidence on that topic. The extent of any causal contribution from matters not constituting actions or proposed actions by the respondent with respect to discipline could not be resolved on the basis of the arbitrator's common knowledge and experience.*
>
> *This is particularly so, given that the available medical evidence was consistent with causes in addition to matters alleged to constitute 'discipline'."*

The Deputy President found the employer could not discharge its onus of proving the Mr Hamad's psychological injury resulted wholly or predominantly from reasonable action taken or proposed to be taken with respect to discipline when there was no medical evidence dealing with that issue. In such circumstances it was unnecessary to consider whether the employer's actions were reasonable. As the availability of a defence pursuant to Section 11A(1) was the only liability issue, Mr Hamad was entitled to succeed.

The decision is likely to have widespread ramifications in the management of psychological injury claims. More often than not such claims have their genesis in a number of incidents which occur in the workplace, not all of which fall squarely within the confines of the eight actions identified in Section 11A(1). Quite often an insurer will not be aware of the whole range of actions the worker alleges to have caused his injury until well after any decision to decline the claim based on reasonable action is made. Wherever the possibility of a defence based on reasonable action is considered it will be necessary to obtain an independent medical opinion on the whole or predominant cause of the injury. As the claim develops it may be necessary to consider whether a further supplementary opinion is required when the workers evidence is served demonstrating other workplace issues as the cause of the injury

Belinda Brown
bjb@gdlaw.com.au